Toward an Informal Curriculum that Teaches Professionalism

Transforming the Social Environment of a Medical School

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The social environment or "informal" curriculum of a medical school profoundly influences students' values and professional identities. The Indiana University School of Medicine is seeking to foster a social environment that consistently embodies and reinforces the values of its formal competency-based curriculum. Using an appreciative narrative-based approach, we have been encouraging students, residents, and faculty to be more mindful of relationship dynamics throughout the school. As participants discover how much relational capacity already exists and how widespread is the desire for a more collaborative environment, their perceptions of the school seem to shift, evoking behavior change and hopeful expectations for the future.

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One of the most consequential and enduring aspects of learning to be a doctor is the formation of one's professional identity—the development of a set of personal beliefs, values, and role expectations that guide and inform virtually all subsequent behavior.[1] Notwithstanding a variety of significant innovations in the formal curriculum of medical education (e.g., the white coat ceremony, small group reflection, and the articulation and assessment of specific professional competencies),[2–4] we believe it is the social environment and the organizational structure of the medical school, the so-called "informal" and "hidden" curricula[5], that have the greatest influence on identity formation. Students tend to internalize and perpetuate the patterns of behavior that surround them—the way they see people treating each other and the way they themselves are treated.[1] In this report, we describe our initial experience with an institution-wide initiative to improve the social environment—and therefore the informal curriculum—of a large medical school.

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Description

The Indiana University School of Medicine (IUSM), a large state school with approximately 1,100 students and 1,200 faculty, is the only medical school in Indiana. Basic sciences are taught at 9 centers around the state; clinical rotations take place primarily at 4 hospitals in Indianapolis including one public and one Veterans Health Administration hospital. Over the past 4 years, IUSM has fully implemented a new formal curriculum based on 9 competencies: effective communication; basic clinical skills; using science to guide diagnosis, management, therapeutics, and prevention; lifelong learning; self-awareness, self-care, and personal growth; the social and community contexts of health care; moral reasoning and ethical judgment; problem solving; and professionalism and role recognition. Each basic science and clinical course addresses both traditional and professionalism-related competencies.

In the present initiative, our intention is to develop an informal curriculum that consistently reinforces the values of the formal curriculum. We hope ultimately to promote mindfulness on the part of every faculty member, resident, and staff member about the values we exhibit and thereby teach in our everyday interactions. We also hope to foster a widespread practice of reflecting on and talking about interactions as they are taking place, for this is what best enables us to continually learn, adjust, repair mistakes (which are inevitable), and harness diversity. To help our students learn and change their behavior, we have committed ourselves to our own continuous learning and behavior change.

Changing patterns of interaction across an entire medical school defies linear planning and design; we do not believe that standardized prescriptive interventions, measurements, and benchmarking will work. Instead, we have adopted the nonlinear perspective of "making ripples in a pond," envisioning our work as introducing constructive disturbances in existing patterns of interaction that other people might then adopt, modify, and propagate.[6] We use an organizational change methodology known as appreciative inquiry, which focuses attention on existing capabilities and successful experiences as a foundation for creating more of what is desired.[7]

We began by assembling a discovery team (DT) comprised of 13 volunteers, ranging from medical students to senior faculty (some of whom helped create our competency curriculum), plus 2 external consultants (ALS and PRW). The team's task was to conduct interviews across IUSM to

identify the best elements of the current informal curriculum. After interviewing each other and noticing the most frequently occurring themes in their own stories, the team members identified 3 areas of focus for the discovery interviews: meaningful experiences, exemplary collaboration, and being entrusted with important responsibilities. The team developed a semistructured 45-minute interview protocol that elicited stories on these 3 topics, and also explored what interviewees value most about IUSM, their vision for IUSM's future, and which individuals made exemplary contributions to IUSM's learning and work environment.

The DT members conducted 80 interviews between February and April 2003. They chose interviewees to maximize the diversity of voices: clinical and basic science departments; students, residents, fellows, and junior and senior faculty, administrative staff and organizational leaders; minorities; individuals who helped develop the competency curriculum and individuals who did not or were overtly skeptical. After each interview, the interviewer recorded in narrative form what (s)he judged to be the most compelling of the three stories from the interview, key themes from the other two stories, and responses to the other questions.

Once the interviews were completed, the DT reviewed the stories, identified key themes, and prepared a public presentation of their findings. This presentation—the Open Forum—was intended to enhance and extend the process of reflecting on the nature and educational impact of IUSM's social environment. Personal invitations were sent to all interviewees and to various organizational leaders. Subsequently, DT members have prepared a written version of the presentation for ad hoc distribution, and have given formal and informal presentations to various individual leaders and groups. The DT continues to meet monthly to share observations about changes in their own and others' behavior and to help each other identify and act upon opportunities to foster change.

RESULTS

Interview Themes

Every interviewee was able to recount positive experiences; collectively, their stories involved all the principal activities of the medical school: clinical care, teaching, research, and administration. Table 1 summarizes the major themes with illustrative narratives.

What interviewees valued most about IUSM were "collegiality of kindred spirits," "wide spectrum of people and clinical experience," "collaborative, nonhierarchical academic community," "encouragement for learning and personal growth," and "commitment to caring for the people of Indiana and for the underserved." The most frequently expressed desires for the future of IUSM were "relationship building between and among researchers, teachers, clinicians, students, and residents"; "more open space and unstructured time to allow spontaneous, informal conversation"; "a greater sense that everyone is pulling together to achieve common goals"; "more diversity in the faculty and student body"; and "interactive engagement of administration at all levels, helping with projects both large and small."

No less striking than the content of the interviews (the stories and themes) were the interpersonal and emotional dynamics. Many interviewers reported that the interviews were uplifting and enjoyable, raising feelings of closeness, respect, joy, and hope for interviewee and interviewer alike.

Public Presentations

The uplifting nature of the individual interviews carried over into the Open Forum. Presenting the themes and stories from the interviews was like holding up a mirror to the IUSM community and reflecting back a very positive image, one that contrasted sharply with the organization's usual self-image in daily conversations that habitually focus on problems and deficiencies. These stories reminded the community of its own quality, its deep reservoirs of caring about patients, students, and colleagues, and its widely shared passion for service, learning, and discovery. One participant said, "Now that I see how good we really are, I have to ask myself why we tolerate it when people aren't as good as this. I can't just look on quietly anymore when people are disrespectful or hurtful. It's no longer okay to remain silent; this is too important."

Observations of Subsequent Rippling

Table 2 illustrates the kinds of observations that DT members have reported since the Open Forum. These range from increased mindfulness about expressing praise to incorporating appreciative interviews into existing activities to an ongoing commitment by the executive deans to reflect on the relational aspects of their work.

DISCUSSION

This report describes our preliminary experience in a multiyear culture change project at a large medical school. Recognizing our inability to predict or control the outcome, we set forth with a method for eliciting and disseminating inspiring narratives about the informal curriculum (the social environment) at its best, with the hope that the relational patterns and values in these stories might be carried forward and amplified in ensuing interactions. Early indications suggest that this is starting to happen for the participants in the discovery interviews and Open Forum. The discovery process appears to be reengaging a sense of hope in these hundred or so participants—an enspiriting that, far from being wistful, is solidly grounded in actual capacities and successes, and inspires them to try out new behaviors. As they begin to see IUSM in a different light (as IUSM's organizational identity changes in their eyes), they begin to interact differently, which might then constitute further evidence of the new organizational identity and call forth even more of the new behaviors, thus creating the potential for a virtuous, self-reinforcing cycle.

Table 1. The Major Themes About IUSM at Its Best, with Illustrative Stories

1. Believing in the capacity of all people to learn and grow: Giving them freedom and support to pursue their professional growth and career development.
   Told by a 5-year faculty member: My greatest source of meaning at work is being a "midwife" to transformational learning for minority students. By believing in them and gathering a faculty who is committed to them and takes them seriously, I have been able to substantially improve minority recruitment, retention, and degree completion rates. But even more satisfying is to see the *personal* change in these individuals. Having been slapped down many times before, they are nevertheless willing to risk investing themselves, and they take on a whole new way of being, of studying, of working with others, and of seeing themselves.
2. The importance of connectedness: Student-teacher, patient-clinician, cross-disciplinary health care team; research collaborators, basic scientist-clinician, across departments and institutions.
   Told by a long-time faculty member: I had a complex patient with a mass in a challenging location. Other organs or vessels might become involved depending on how the surgery was conducted. I called in colleagues from thoracics and urology, and we each saw the patient separately and then reviewed the information in the room, with residents and students also there, listening. All communicated effectively with the patient and her husband, who learned about the complexities of her problem as well as a lot about her disease. The students and residents heard us talk about possible approaches and sequellae to the operation, including our thoughts about the benefits and possible down sides of each option. The surgery went well, and the three of us colleagues and our residents continued to collaborate effectively on every aspect of the follow-up. I coordinated this collaboration. It worked so well because these colleagues are long-time friends. The thoracic faculty was my chief resident when I was an intern; and the urology faculty was a resident when I was a student on his service. We have known, respected, and trusted each other for a long time. The patient still sends me a Christmas card every year.
3. The importance of passion: For patient care, learning, teaching, trying new things, creating new knowledge.
   Told by a third-year student: I worked with a neurology attending who had great energy and the ability to engage everyone involved on the service. She was a great role model and leader who had us actively involved with patients. She taught and inspired us to take initiative and to learn more. She also inspired patients and families with her dynamic relationships. We responded by taking the initiative, having fun in learning about and treating patients.
4. The wonderment of medicine: The discovery and continuing appreciation of the profound nature of our work.
   Told by a resident: I attended the funeral of a patient who died 1 month after I had left the service. I heard that this 12-year-old patient had died, and contacted the social worker who gave me the information regarding the funeral. I got up for the Sunday morning funeral although the time could have given me an out. The child had been intubated throughout the time she was under my care; consequently, we had not had much contact. But I had spent some time with the family and felt closer to them than I had to other families. Sitting at the funeral, I became aware of the weight of what we do and the enormousness of the issues we deal with. I was deeply touched by the fact that this Spanish-speaking lower-socioeconomic family was from a very different background than me but that the tears were just the same. To me, it was striking how many different sorts of people came together at this funeral and the great importance of being there…being in the moment. This "being there" sometimes gets lost when we're worrying about the drips (IV fluids) and numbers of critical medical care. My strong sense of spirituality and deep caring (it may sound superficial, but I really do care about patients), my wish for insight regarding my patients, and my belief in total patient care were what I brought to this experience. I had no particular role models that guided me to this activity. It just felt like the right thing to do. I wonder: how do I share this activity with others at the school to pass on the meaning?

Having observed the transformational potential of these initial conversations, our next step in the project is to engage many more participants. DT members are looking at existing forums (e.g., grand rounds), committees (e.g., admissions and promotions committees), student organizations, school-wide events, and other opportunities to encourage more people to notice and talk with each other about the way they are interacting, and to raise more generally throughout the medical school the hope and belief that the desired culture of collaboration, connectedness, passion, and wonder can truly be realized. We are also exploring two other high-leverage opportunities: the selection and orientation of new community members (students, residents, faculty, and leaders) and leadership development (programs for student leaders, new R2s and chief residents, unit chiefs, department chairs, and deans). As the project continues, we will undertake a systematic evaluation, looking for changes in students' responses to the quantitative and qualitative components of the annual American Association of Medical Colleges Graduation Questionnaire as evidence that the informal curriculum is changing.

Two theories of organizational change inform this project. Appreciative Inquiry (AI) builds on the social constructionist insight that "reality" (how people perceive their environment) is created in conversation, and depends heavily on how attention is focused.[8] Typical management conversations in organizations (like most clinical conversations) focus attention on what is wrong and how to fix it. This creates a general perception of deficiency and sets in motion a self-fulfilling dynamic of emotions (fear and shame), behaviors (defensiveness and counter-attack), and expectations (hopelessness). AI transforms that dynamic by calling attention to what is right, what is working, and how to have more of it. Expectations and behavior thus organize around a core perception of capability and hopefulness rather than deficit. AI also activates a dynamic of community building with its extensive use of storytelling.

The other theory is Complex Responsive Process (CRP), the first complexity theory developed specifically for the social sciences (other complexity models—notably Complex Adaptive Systems—come from the natural sciences or cybernetics and are applied to organizations only by

Table 2. Examples of Changes that Discovery Team Members Have Observed in Themselves and Others Following the Public Presentations of the Discovery Interviews

- A faculty member observed a sense of deepening connection between interviewers and interviewees—seeing them around campus, feeling more connected, even arranging follow-up meetings.
- One person was moved at a budget meeting to give voice to his personal feelings of heartbreak at program cuts that had to be made, even though there was no precedent at that particular meeting for such personal comments.
- At a meeting of a standing committee, one participant rearranged the furniture to enable people to sit closer together.
- A faculty member invited new chief residents to reflect on a moment when they felt "on top of their game." A lively and engaging conversation ensued. He commented, "I can't stop thinking about this new way of seeing."
- The faculty members on a major medical school committee have reserved time on their agenda to express appreciation for each other's contributions to each meeting.
- At the end of a day, a senior faculty member was observed making a significant detour from his path to the parking garage to escort a "lost-looking couple" to their destination in a hospital. The observer reports seeing this kind of behavior "more and more."
- In a summer session problem-based learning program, students exhibited outstanding collaboration—learning and growing together. The instructional method promotes collegiality. Relationship was the foundation for learning.
- The method of appreciative storytelling was disseminated by its incorporation into the retreat for the faculty mentors in the vertical mentoring program. Many faculty participants expressed their intention to use this method in their mentoring groups.
- Inspired specifically by reflections on the power of appreciation at DT meetings, an associate residency program director passed along to all the residents a rare and well-earned compliment that had been related to her regarding the residents' adaptability and cooperation in implementing schedule changes needed to meet the 80-hour work week requirements. She received a number of thank you e-mails in response. In addition, many of the medical students had let the residency director know that they enjoyed working with the residents and she passed this along as well.
- After hearing a report of the DT activities, the dean and executive associate deans asked the DT's external consultants to meet with them monthly to help them reflect on relational aspects of their administrative work.
- The DT has tripled in size since the interviews were conducted. Several of the original interviewees have asked to get involved, as have many people who heard presentations of the DT's findings.

analogy).[6] CRP, too, focuses on conversation, describing how patterns of meaning (e.g., an organization's identity) and patterns of relating (e.g., the way people talk with each other or the breadth of participation in decision making) arise, propagate, and evolve spontaneously in the ongoing flow of human interaction. Although these patterns cannot be planned or controlled, they are susceptible to influence, albeit unpredictably. Small changes in behavior or new ideas can sometimes spread quickly and widely, transforming organizational patterns of thinking and interacting. The theory of CRP encourages organizational change agents to focus their attention not on elaborate idealized designs but rather on what is actually happening—to participate in and foster reflection on the here-and-now interactional processes of the organization, to notice what patterns are propagating and how, and to explore opportunities to act differently, thus introducing the possibility of new and potentially more desirable patterns. The theory also legitimizes not knowing and paradox, thus weaning leaders from unrealistic and anxiety-provoking expectations of control.

In summary, the recognition that the workplace and educational culture of a medical school constitutes an informal yet potent element of the curriculum has led us to undertake an organizational change project based on appreciative storytelling and reflection on action. For the hundred or so people who have participated to date, we see evidence that IUSM's organizational identity is shifting in a way that raises hope and expectations and prompts new behaviors that are consistent with the values of the formal competency-based curriculum. Our hope is that the enthusiasm and the myriad small successes unleashed thus far will grow to become a person-to-person cascade of change across the organization.

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